Public Health Watch

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METROPOLITAN HEALTH DEPARTMENT OF NASHVILLE AND DAVIDSON COUNTY, TENNESSEE

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Safety Belt Use in Davidson County, Tennessee

Melissa Garcia, M.P.H., Public Health Epidemiologist II

Background

The goal of promoting and mandating safety belt use is to reduce injuries and fatalities in motor vehicle accidents. Motor vehicle accidents (MVAs) are a leading cause of unintentional injury deaths, accounting for 39% of all accidental deaths in 1999 in Davidson County, Tennessee. Nationwide, MVAs also rank among the top ten leading causes of death. Davidson County's age-adjusted mortality rate from MVAs is slightly higher than that of the United States (U.S.) – 1999 Davidson County: 16.04 per 100,000; 1999 U.S.: 15.5 per 100, 000.

Safety belt use in Tennessee has been mandated by law since 1986. The Tennessee Health Status Report of 1999 reported that 66% of Tennessee adults always wear safety belts. In the United States, 69% of the adult population reports always wearing a seat belt. The Centers for Disease Control and Prevention's *Healthy People* reports state that the goals for nationwide use of safety belts are 85% by the year 2000 and 92% by the year 2010. Davidson County should reach those goals, as well. Use of safety belts in adults and children and the use of child safety seats can be estimated from safety questions in the 1996 and 1998 Davidson County Behavioral Risk Factor Surveillance Surveys (BRFSS).

Motor vehicle accidents are a leading cause of unintentional injury deaths in Davidson County, accounting for 39% of all accidental deaths in 1999.

Findings

Adult Safety Belt Use

- In 1996, 66% of Davidson County adults reported always using safety belts (Figure 1). This percentage increased slightly to 68% in 1998. From 1996 to 1998, rates of use rose for men and women, whites and blacks. However, women were consistently more likely to wear safety belts than men – 72% of women compared to 58% of men in 1996 and 74% of women compared to 62% of men in 1998. Blacks had lower rates of safety belt use than whites and also increased use less than whites from 1996 to 1998. 68% of whites wore safety belts in 1996 compared to 56% of blacks. In 1998, 71% of whites always wore safety belts, while 57% of blacks did.
- Considering safety belt use by age groups reveals that use is more common in older age groups (Figure 2). In 1996, it ranged from 56% in the 18-24 year old group to 72% in the over age 65 group. In most age groups, there was an increase in use in 1998. The largest increases were of 5% in the 45-54 and 65+ age groups.
- Education level also appeared to influence safety belt use. Overall, safety belt use was higher in groups with higher education (Figure 3). In 1996, the percentage of persons who reported always wearing seat belts went from 52% in persons with less than a high school diploma, to 60% in those with a high school diploma, to 66% in those with some college, to 78% in those with a college

continued on page two

In This Issue

Figure 1. BRFSS Respondents Who Reported Always Use Safety Belts, Davidson County, TN, 1996 and 1998

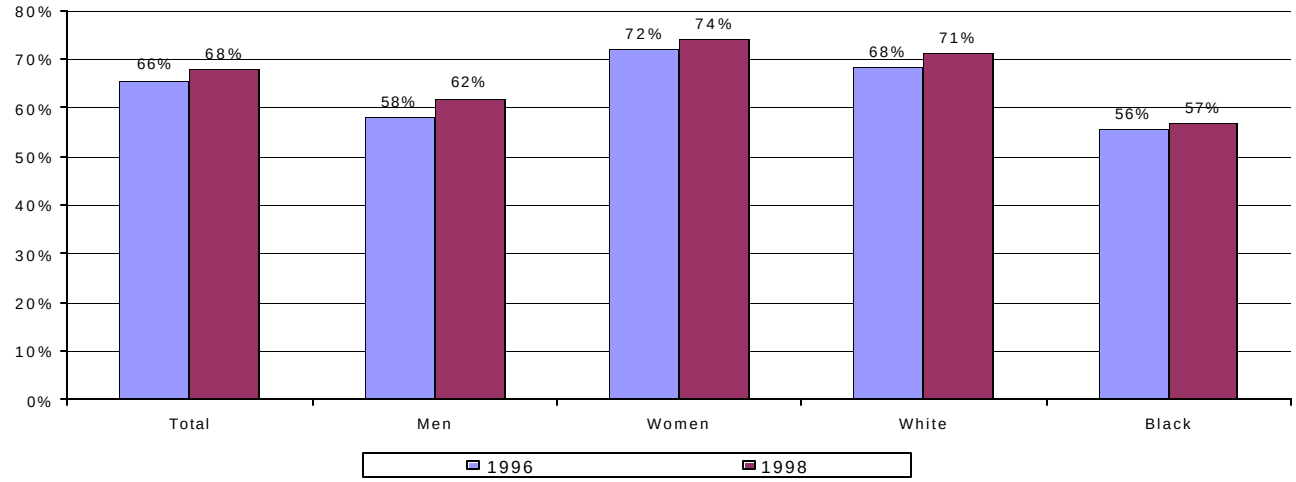


Figure 2. BRFSS Respondents Who Reported Always Use Safety Belts, By Age Group, Davidson County, TN, 1996 and 1998

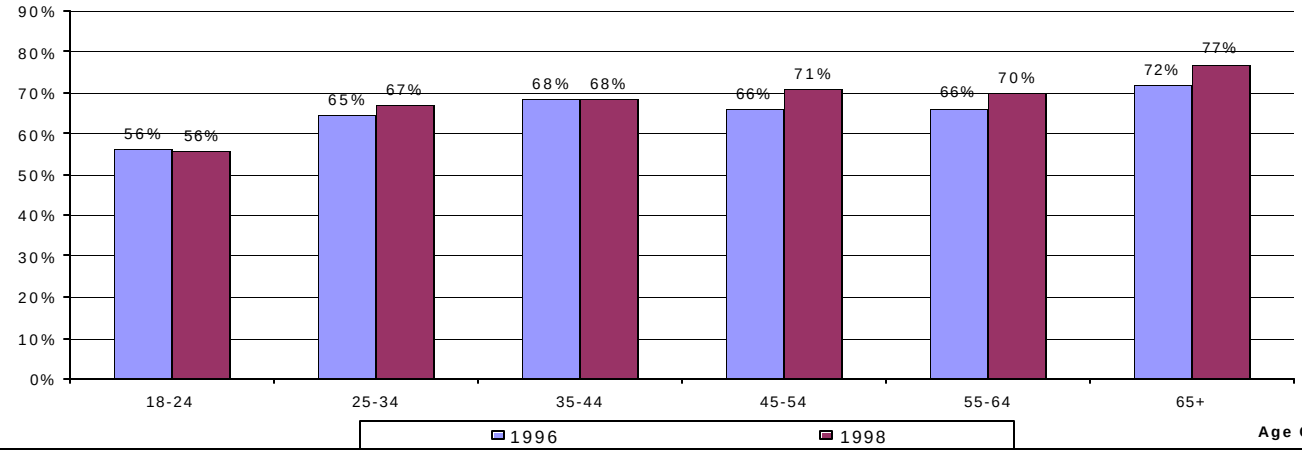
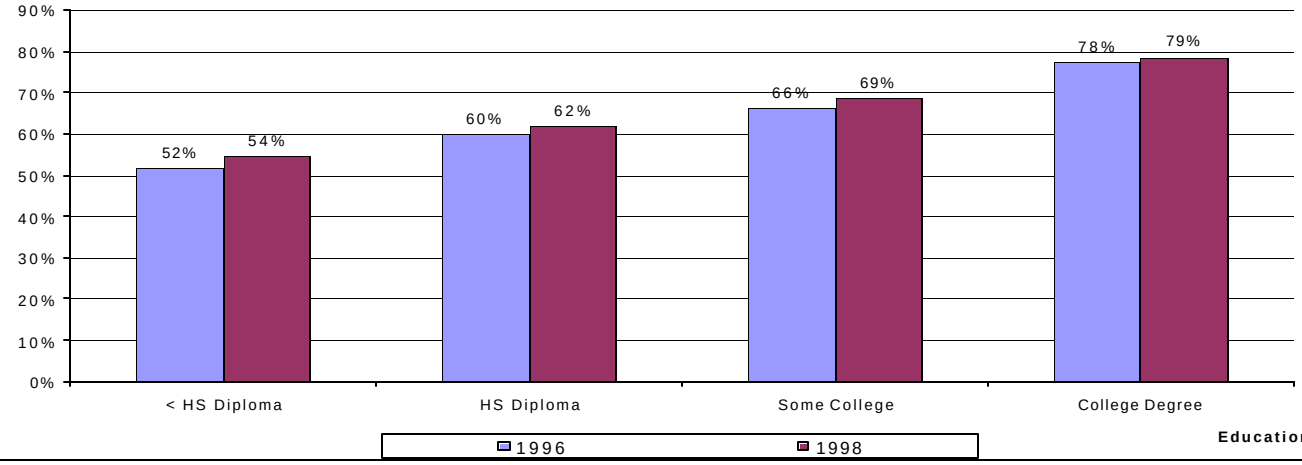


Figure 3. BRFSS Respondents Who Reported Always Use Safety Belts, by Education Level, Davidson County,TN, 1996 and 1998



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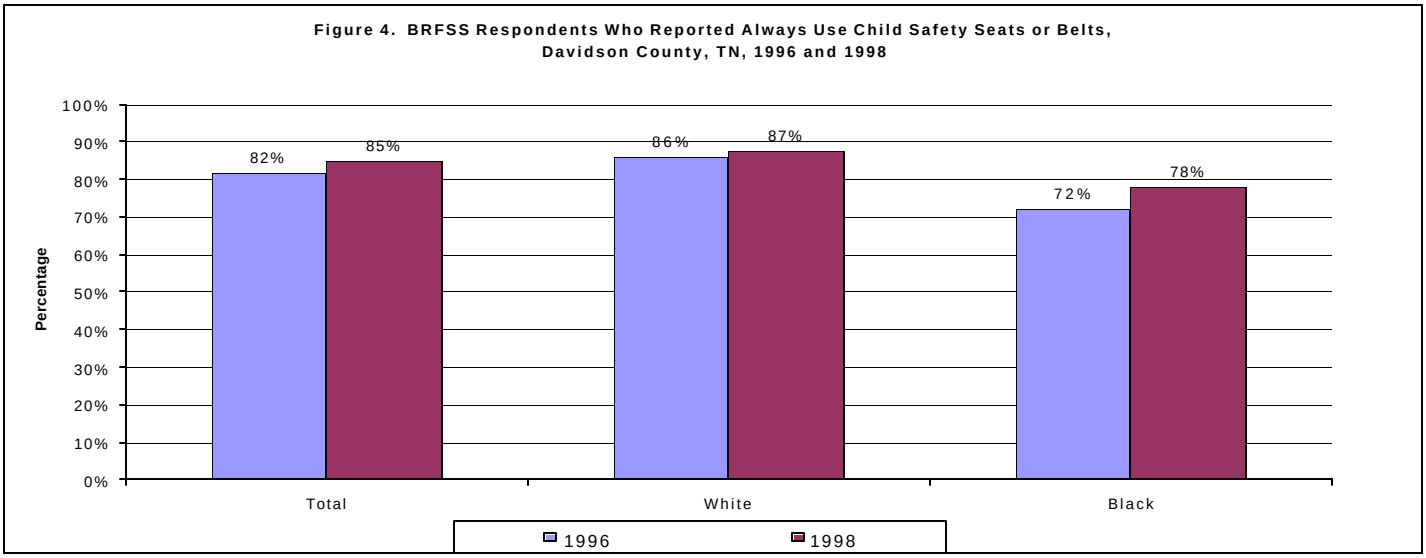
degree (Figure 3). There was an average 2% increase in each education group in 1998 – 54% of residents with less than a high school diploma always wore safety belts, while 79% of those with a college degree did.

Child Safety Restraint Use

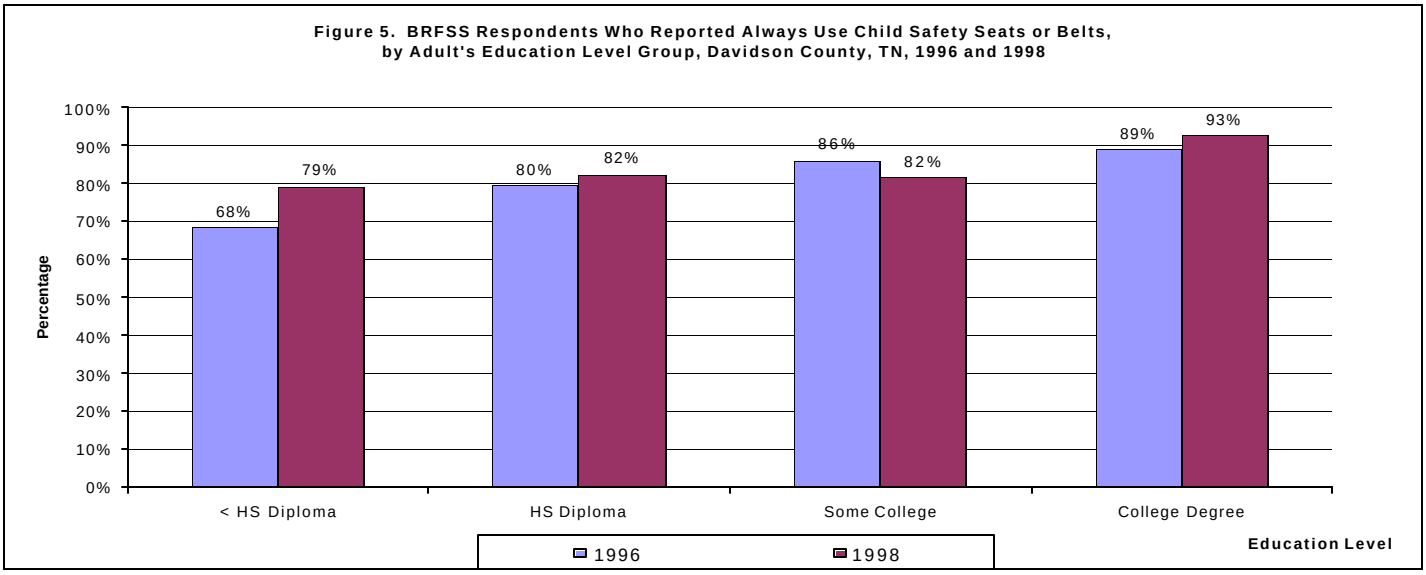
- Davidson County adult residents reported much higher rates of safety belt (and safety seat) use for the children under age 16 in their household than they did for themselves. In 1996, 82% reported children always wear safety belts or are restrained in child safety seats (Figure 4). This percentage rose to 85% in 1998. Rates were higher in whites than blacks for both years – 1996: whites 85%, blacks 72%; 1998: whites 87%, blacks 78%. One of the largest increases in safety belt use over the 2 years between surveys was a 6% increase in use of child safety restraints by black residents.

Figure 4. BRFSS Respondents Who Reported Always Use Child Safety Seats or Belts, Davidson County, TN, 1996 and 1998



- The education level of adults in Davidson County appears to be associated with use of child safety restraints. In 1996, 68% of persons with less than a high school diploma used child safety restraints, while 89% of those with a college degree did (Figure 5). In 1998, the percentages rose in most education groups. The rate increased 11% in respondents who did not finish high school, and rose 4% in respondents who completed college.

Figure 5. BRFSS Respondents Who Reported Always Use Child Safety Seats or Belts, by Adult's Education Level Group, Davidson County, TN, 1996 and 1998



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Comparison of Davidson County to the U.S.

- Davidson County data was age-adjusted to the U.S. 2000 standard population for comparison with the U.S. 1997 BRFSS results (Table 1). Comparing the adjusted rates for always using safety belts, we find that in 1996 Davidson County rates were consistently lower than the U.S. rates. The largest difference was a 7% lower rate in safety belt use for blacks. In 1998, Davidson County rates are very close to those of the U.S., but the rate for blacks was still the most different with a 4% shortage compared to U.S. rates.

Table 1. Age-adjusted rates* of safety belt use in the U.S. and Davidson County.

Population	U.S. 1997 BRFSS	Davidson County 1996 BRFSS	Davidson County 1998 BRFSS
Total	69%	66%	69%
Male	62%	59%	62%
Female	75%	72%	74%
White	70%	68%	71%
Black	63%	56%	59%

*Age-adjusted rates are based on the age distribution of the U.S. 2000 standard population, they are slightly different from the weighted BRFSS rates for Davidson County reported earlier.

- Overall, reported use of safety restraints for children under age 16 in Davidson County was slightly lower than the rates in the U.S. (Table 2). The biggest difference in Davidson County was that the 1996 rate for blacks was 12% lower than the U.S. rate.

Table 2. Age-adjusted rates* of child safety restraint use in the U.S. and Davidson County.

Population	U.S. 1997 BRFSS	Davidson County 1996 BRFSS	Davidson County 1998 BRFSS
Total	85%	83%	83%
Male	85%	83%	86%
Female	85%	84%	81%
White	87%	88%	84%
Black	82%	70%	80%

*Age-adjusted rates are based on the age distribution of the U.S. 2000 standard population.

Discussion

How do we compare to U.S. and to *Healthy People 2000* and *2010* goals? We have not reached the 85% *Healthy People 2000* goal. We have much farther to go to reach the *Healthy People 2010* goal of 92% safety belt use. Nonetheless, Davidson County's overall rates are in-line with those for the nation. The race, gender, age, and education trends in the Davidson County data are similar to those reported by more in-depth safety belt use studies.[1]

Davidson County overall rates for use of child safety restraints are also similar to those for the U.S. However, the 1996 rates for black respondents were about 12 points lower than in the national rates. The rate improved in 1998, with only a 2 point differential between Davidson County and the U.S.

While it is promising that Davidson County safety belt use is nearly the same as the rates for the U.S., we must note the potentially unreliable nature of the data since it comes from self-reports and not direct observation. Studies have been done to observe, first-hand, whether car drivers and passengers wear seatbelts.[2,3] We are reassured that our results are close to realty based on the findings of these studies. The results from these studies tell us that safety belt use can be road-specific – people traveling on interstate highways are more likely to wear safety belts than people traveling on city streets.[2] Some observations from these studies support the findings we have from our surveys. They find that more drivers (as opposed to passengers), more women, and more people age 25 or older wear safety belts.[2] Recent research done by the University of Tennessee Transportation Center found that residents in urban counties wore safety belts more often than rural county residents.[3]

The three groups that require the most attention to increase safety belt use rates are blacks, people under age 25, and people without college education. Many things in Davidson

continued on page five

County and statewide already are being done to increase safety belt use. Recognizing that lower rates of safety belt use in blacks is not only a problem in Davidson County, but also for the nation, the U.S. Department of Transportation and Nashville's Meharry Medical College have joined efforts in a nationwide initiative to increase safety belt use in blacks.[4] On July 1, 2001, a new law took effect which made it mandatory for all passengers between ages 4 and 17 to wear safety belts when riding in any seat of a vehicle operated by a person with a learner's permit or intermediate driver license. This new law will protect passengers in cars driven by the high-risk teenage drivers. Even though safety belt laws in Tennessee can only be enforced when vehicles are stopped for another violation, the state is making efforts to improve safety belt use through the "Click It or Ticket"[5] program. There is still room for improvement, especially in reaching persons without a college education.

Technical Notes

The data was coded to combine the separate questions (#76 and 77) from 1996 to match the combined question regarding child restraints (#14) used in 1998. These questions ask how often the respondent or children under age 16 in his/her household wear safety belts or use child safety seats when driving or riding in a car. Possible answers were 1) always, 2) nearly always, 3) sometimes, 4) seldom, and 5) never. For simplicity these answers have been reduced to 1) always and 2) not always. Many publications use this method of dichotomizing the data.[1]

The data from each survey year were weighted so that the gender-race-age distribution of the respondents to the BRFSS would match the gender-race-age distribution of Davidson County, Tennessee in those years. Persons with unknown age were put in the 65 years and older group. Persons with unknown race were put in the other races group. Persons with unknown education were put in the less than High School Diploma group.

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[1]Shinar D. Demographic and Socioeconomic Correlates of Safety Belt Use. Accident Analysis and Prevention. 1993; 25:745-755.
[2]Wells JK, Williams AF, Lund AK. Seat Belt Use on Interstate Highways. American Journal of Public Health. 1990;80:740-742.
[3]University of Tennessee Transportation Center. 2000.
[4]Meharry Medical College. Achieving a Credible Health and Safety Approach to Increasing Seat Belt Usage Among African Americans. 1999.
[5]Tennessee Department of Transportation. 2001. http://www.tdot.state.tn.us/ClickItorTicket/.

Part Two of Syphilis Epidemic Investigation Report Released

Nashville has experienced a syphilis epidemic since 1996. The first part of an investigative report on this epidemic titled "Epidemiology of Primary and Secondary Syphilis in Nashville and Davidson County, Tennessee" was released in October 1998. An effort to examine risk factors contributing to the current epidemic continues. Recently the Division of Epidemiology released the second part of a two-part investigative report on Nashville's syphilis epidemic. The second part of the report titled "Primary and Secondary Syphilis in Nashville and Davidson County, TN: 1996 – 1999 Epidemic Risk Factors Examined" examines the risk factors associated with the syphilis epidemic for the purpose of syphilis prevention and control throughout Nashville.

In Part Two, multiple approaches were used to conduct the investigation. The methodology includes descriptive epidemiology, a literature and government document review, an analysis of local relevant data, a TennCare utilization data matching study, a Metropolitan Health Department (MHD) clinic visitation data analysis, and a series of three matched case-control studies.

The report finds that both social and biological factors influence the occurrence of syphilis. Although the transmission of syphilis between and among sexually active persons is a direct result of individual behaviors, the social factors examined in this report reaffirm and support the environmental and ecological conditions that increase and intensify the risk of each individual's behavior and thereby serve to promote and sustain the epidemic. The report identified several risk factors (or possible risk factors) relating to the Nashville syphilis epidemic. They include:

1. Illegal sex and drug related activities among syphilis cases are important contributors to Nashville's current syphilis epidemic. It is estimated that the risk of syphilis acquisition increased 16.7% to 62.6% per each additional sex related charge and increased 4.9% per each additional drug related charge based on study data. From 1994 to 1998 there were 99 primary and secondary (P & S) syphilis cases that had sex related criminal charge records. These criminal charges included a total of 494 sex related charges and 312 P & S syphilis cases had drug related criminal charge records with a total of 1,589 drug related charges. Given these facts, the opportunities for these cases to serve as "core transmitters" to spread syphilis in Nashville is substantial.

2. Syphilis cases in the homeless population may be an addition to the "core transmitters" in Nashville's syphilis epidemic. However, it is realized that this statement is based on limited data and further investigation is needed.

continued on page six

3. Potentially unreported syphilis cases may contribute to Nashville's existing syphilis "core transmitters" pool. TennCare utilization data matching found 312 TennCare provider-diagnosed P & S syphilis patients were not matched with MHD reported P & S syphilis cases during 1994-1998. Although a MHD Sexually Transmitted Disease (STD) Clinic audit data provided some evidence of underreporting and/or misdiagnosis, the impact of underreporting and misdiagnosis on Nashville's syphilis epidemic is unknown at this time. A study is warranted to assess and verify these 312 TennCare provider-diagnosed syphilis patients.

4. The decrease in public health services capacity, coupled with the increased needs and demands for STD services in the community, may suggest missed opportunities for syphilis prevention and control.

5. Introduction of TennCare in 1994 changed the dynamics of syphilis care in this community, which may have had some impact on the syphilis epidemic.

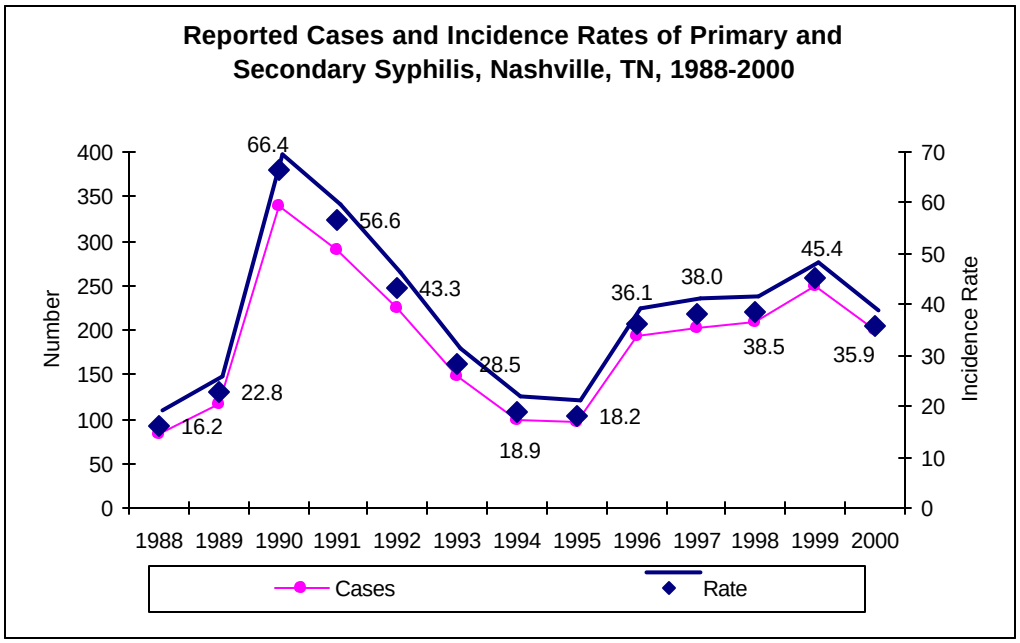
6. Nashville's social environment and ecological conditions provided soil for the current syphilis epidemic to grow.

7. The conjunction of syphilis' unique biological and biomedical features with a favorable social environment resulted in Nashville's current syphilis epidemic.

Based on the findings, the report recommends that we:

1. Continue to enhance the syphilis surveillance system.
2. Continue to strengthen community involvement and partnerships.
3. Expand outbreak response efforts to include the homeless population.
4. Continue to provide quality clinic services, laboratory services, and health promotion interventions.
5. Invest in Nashville's public health infrastructure.

The full report is available on the Metropolitan Health Department's website: http://healthweb.nashville.org., or you may call 615-340-2151 for a printed copy.



Note: Numbers displayed in figure are incidence rates.

Editor's Note:
Dr. Kimberlee Wyche-Etheridge joined Metro Health Department as Director of Maternal Child Health on July 30, 2001. Dr. Wyche-Etheridge comes to Nashville from Boston where she worked at Harvard Medical School and as a practicing pediatrician in a clinic. She accepted the invitation of *Public Health Watch* to write the following article for our readers.

Pediatrics, Public Health, or Both?

Kimberlee Wyche-Etheridge, M.D., M.P.H.

As we rounded the corner of the seventh flight of stairs the light grew dim. The empty socket hung out of reach above our heads. "Someone stole the bulb again," Judy remarked, as she took a pause to swat a fly and catch her breath before attempting the remaining seven flights. We could hear the sounds of the rodents scurrying on the next landing, muffled by the screeches of children who came barreling down the stairs, unimpressed that the elevator once again was not working. Seven more flights to go. The hallway was oppressively hot and the air was heavy with the poignant smell of urine and trash. When we reached the top we put down the heavy bags containing the baby scale, medical supplies, developmental toys, and abundance of pamphlets and other reference material we were bringing to our new mother, and took a deep breath before knocking on the door.

Shana, who we had undertaken this journey to visit, was a 21-year-old young woman who had recently earned her high school diploma. She had finished her program while on bed rest due to complications from her pregnancy. Taira Marie was born healthy three days prior to our visit at 36 weeks, weighing just under 7 pounds. Judy, who was a Public Health Nurse, had been visiting Shana since she was pregnant with her first child Stevie, 5 years ago. Stevie had been a premie, born seven weeks early after Shana developed problems with her blood pressure and kidneys. He had spent 2 months in the Neonatal Intensive Care Unit, but was doing relatively well.

This housing project, which sat on the poor side of the harbor in one of Boston's most disenfranchised, racially divided neighborhoods, Judy knew like the back of her hand. After all, she had been walking these stairs and others, visiting mothers and children for almost 20 years. "She is doing well. I am very proud of her!" Judy told me. "It has been a struggle, Stevie was recently hospitalized for severe asthma, and the hospital staff gave her a hard time because she couldn't stay in there with him." We knocked.

Dressed sparsely, using a crumpled magazine as a fan, beads of sweat on her forehead and neck, Shana came to the door and smiled when she saw Judy. They exchanged hugs. She led us in and then double bolted the door. Inside the apartment it must have been close to 85 degrees. The windows were open and a small fan roaring in the corner of the room did nothing to cool things off. There was no breeze.

Kimberlee Wyche-Etheridge, M.D., M.P.H., Director of Maternal Child Health

The living room, which doubled as a dining room and bedroom for Stevie, was in disarray. She sheepishly moved a pile of laundry from the sofa, checked for anything crawling on the cushions, and then offered us a seat. Stevie was lying on the tiled floor in front of the television playing with a plastic car, and the newborn, who was lightly swaddled, slept in the confines of a small dresser drawer that doubled as a bassinet…

This is one of the powerful memories I have from the summers during high school and college when I worked with Boston's Public Health Nurses. With my classroom Spanish, I helped translate for the nurses and, accompanied them on home visits to some of Boston's most vulnerable residents. Years later, they never believed how much of an influence they had on my career path.

I grew up in one of these inner city Boston neighborhoods, and much to my parents' surprise proclaimed at the age of 4 that I was going to be a medical doctor. As I went through high school and college this never changed, and they supported my decision through the good times and the rocky times. I attended the University of Massachusetts Medical School, and did my internship and residency in pediatrics at the Children's National Medical Center in Washington DC. While in the Nation's Capital, the non-medical issues that affected my patients' health and that of their families, became increasingly clear and frustrating. Issues like poverty, access to care, low expectations of personal health, and the "r" word, racism, both

continued on page eight

institutional and internalized, seemed to undo everything that we were able to do in the clinics, hospitals, and emergency rooms.

We live in an interesting time, 2001. As part of the richest nation in the world with the leading scientific advances, one of the highest standards of living and the ability to waste everything from paper to food, it remains amazing to me that the challenges we are facing as far as improving the health of our vulnerable populations, i.e., women and children, has not significantly improved over the last forty years. When we concentrate just on women and children of color, the lack of health status improvement is even more distressing.

Health disparities have received a lot of attention over the last several years. In the winter of 2000, the Surgeon General, Dr. David Satcher, committed the nation to eliminate health disparities. However, as we continue to do the research and gather the data, people are continuing to die at alarming rates.

African American and American Indian/Alaskan Native women report the shortest life expectancies, almost 10 years shorter than white women. The death rates from heart disease, cancer, and cerebrovascular disease for women of color are 2 to 3 times higher than whites. The "diet of poverty" that many of these women consume has led to high rates of obesity, diabetics, heart disease, and death. If you have the chance, travel to an inner city supermarket, and see how difficult it is to eat healthy in areas where fresh fruits and vegetables are of poorer quality, often scarce, and are more expensive. Most likely there is a 99-cent burger or fried chicken place closer to home than a supermarket. Experience it. Where do we put the blame?

Most women of color are less likely to enter into prenatal care in the first trimester of their pregnancy, 66% vs. 82% for whites. Again, what are some of the barriers these women are facing? If you have never waited more than one hour to see your health care provider, never experienced culturally incompetent care, never passed a day without worrying about fulfilling basic needs of food and shelter for your family, and have grown up in a culture that does not trust the established medical system, then it is difficult to answer why prenatal care is not always a top priority.

African American women have the highest rate of low and very low birth weight babies, over 2 times greater than whites and the neonatal and post-neonatal death rates exemplify an even greater gap. We have expanded Neonatal Intensive Care units and increased prenatal care services, but have not addressed some of the more difficult issues affecting women's health long before conception occurs. How do we define, assess and limit the effects of "inherited stress" on maternal and infant mortality?

There are many other health disparities that we must be open to realize and confront. I am honored and enthusiastic to have joined the staff of the Maternal Child Health team. We have a dedicated group of public health advocates, who are already hard at work addressing some of these issues. Through home visiting programs, resource and referral centers, assessment programs and school health programs, hundreds of infants, children and mothers are provided with many of the tools needed to stay healthy and alive.

I look forward to the challenge of strengthening these MCH programs while also seeking out new opportunities to work across divisions, and with other organizations that have as their primary focus, the health and well being of Davidson County's women and children. In order to get different results, it is going to require stepping back, reassessing the issues that cause the problems we as a community are facing, and being open to new approaches, new ideas, and new opportunities to act. Maternal Child Health is poised to lead that charge.

These are some of our challenges. Let's pull together and make a difference in the life of our future generations.

Public Health Infrastructure: A Status Report

We are a Nation at risk. We face a world of new threats and ancient foes. Is public health's infrastructure prepared to respond?

Microbes are coming to our shores, hitching rides on travelers, immigrants, and food--and they are here to stay. West Nile Virus and multi-drug resistant tuberculosis (TB) are but a few examples of the ceaseless traffic across borders that cannot be hermetically sealed.

Today, 20 percent of TB cases around the world are now resistant to the drugs previously used to successfully treat the disease. In the 1940s and thereafter, when penicillin was rightly touted as a medical miracle, moderate doses of penicillin and other drugs in its class cured all *staphylococcus* infections. By 1998, 9 out of 10 *staphylococcus* infections—90 percent—were resistant to penicillin and its related compounds.

These threats are man-made, but they are not intentional. Yet we are now also plagued by the threat of a whole new category of deliberate horrors—the death and destruction caused by bioterrorism, the willful unleashing of infectious agents into unsuspecting populations.

Chronic diseases also pose an increasing threat. More than 90 million Americans live each day with chronic disease. Heart disease, cancer, diabetes, and other chronic conditions now account for 70 percent of all deaths in the United States each year and for one-third of the years of potential life lost. This tragedy is compounded by the fact that these deaths are largely preventable.

continued on page nine

Public Health Infrastructure: A Status Report....continued from page eight

Chronic diseases and high-risk behaviors also rob our children of healthy futures. Automobile injuries, homicide, and suicide account for 60 percent of deaths among youth. Five million of today's school children will die prematurely from tobacco use. Twenty-six percent of teens are overweight and at increased risk of high blood pressure, stroke, and diabetes. And one million teenage girls will become pregnant in the United States this year--the highest rate for any developed country.

How can we protect ourselves from these threats? Our national public health infrastructure is the first—and in many cases the *only*—line of defense. Like our system of national military preparedness, our public health armaments—a skilled professional workforce, robust information and data systems, and strong health departments and laboratories—must be at a constant state of "battle readiness" nationwide. Because many environmental and health threats know no boundaries, we can afford no weaknesses in our line of defense. Either we are *all protected*, or we are *all at risk*.

In the past century, we have witnessed unprecedented advances in science, technology, longevity, and overall standards of living. With breakthroughs like the mapping or the human genome, it becomes easy--and tempting--to believe that this progress will continue at an ever accelerated pace, allowing us to conquer new problems as they occur.

Yet, as we've seen, some of these very advances have spawned new threats. Only with a uniformly strong public health infrastructure can we combat these threats. Our immediate investment today will buy something truly priceless for tomorrow--enhanced protection for all Americans and improved health for future generations.

Excerpted from Executive Summary and Conclusion of *Public Health's Infrastructure A status Report* prepared for the Appropriations Committee of the United States Senate by the Department of Health and Human Services and the Centers for Disease Control and Prevention.

The Courage To Do the Right Thing

Stephanie B.C. Bailey, M.D., M.S.H.S.A.

I applaud our city's Board of Health for issuing state legislators a health warning not to squander the Tobacco Settlement dollars!

The Board of Health has openly questioned the irresponsibility of state legislators for using Tobacco Settlement funds as a stopgap measure to balance the state's budget.

The legislators' current budget failed to earmark any of the Tobacco funds to address smoking cessation or any other initiatives that benefit the "health of the public." Just balancing the budget is irresponsible if "how" you do it is not important. Using tobacco dollars is a "quick fix" and requires no thought, less time in session, and seems to have fewer people upset.

Each legislator should take a closer look at their own community when deciding the best use of these funds. Every one of their constituents has had a family member or a friend who has suffered or died as a result of a tobacco-related illness. And every health council—all 95 counties in Tennessee—has listed tobacco use and abuse among their top five priority issues.

An important step in breaking the grip that tobacco has on our community is to put forth prevention efforts targeted at those most likely to start using tobacco-—our youth. According to the Centers for Disease Control and Prevention, of adults who smoke, 80 percent started before age 18.

In the most recent youth survey by the Health Department, 67 percent of Nashville high school students say they have tried cigarette smoking. The survey also found that one-third of high school students currently smoke.

It should come as no surprise to find that Tennessee ranks next to last in spending money to discourage people from smoking.

The health effects are devastating. Cancer continues to be the number two killer of Nashvillians. Lung cancer has supplanted breast cancer as the leading cause of cancer deaths among women. Virtually all of these types of deaths can be attributed directly to the use of tobacco. Tobacco use remains the number one preventable cause of death and disability according to the CDC.

The responsible use of the tobacco settlement dollars is a once in a lifetime chance to place significant funding toward public health resources that without question will improve the lives of future generations of Nashvillians. We have a health care system that embraces and focuses on illness. Yet, less than one percent of the Gross National Product goes for prevention efforts and now we have legislators taking these dollars that were earmarked in the original agreement for PREVENTION!

Legislators have now wasted the time and efforts of their own subcommittee chaired by Senator Roscoe Dixon. These same legislators should know that more people are upset about this than you may be aware.

It is imperative that the tobacco settlement dollars support tobacco-related health needs, including education and prevention—especially among our community's youth.

The misuse of the settlement funds means more Tennesseans will become ill and die due to tobacco use. We will see more children get addicted to tobacco. We can also expect annual medical costs in Tennessee due to smoking to spiral up from its current $1 billion mark.

Reported cases of selected notifiable diseases for July/August 2001

Disease	Cases Reported in July/August		Cumulative Cases Reported through August	
	2000	2001	2000	2001
AIDS	85	26	295	141
Campylobacteriosis	6	6	27	24
Chlamydia	397	327	1,673	1,428
DRSP (Invasive drug-resistant *Streptococcus pneumoniae*	5	2	29	17
Escherichia coli 0157:H7	4	1	5	4
Giardiasis	6	5	20	13
Gonorrhea	468	303	1,647	1,159
Hepatitis A	3	10	37	26
Hepatitis B (acute)	6	2	32	11
Hepatitis B (perinatal)	4	1	19	12
HIV	68	55	328	225
Influenza-like Illness	0	0	705	131
Neisseria meningitidis disease	1	0	7	7
Salmonellosis	43	14	59	36
Shigellosis	5	2	15	5
Syphilis (primary and secondary)	27	22	125	63
Tuberculosis	12	18	58	45
VRE (Vancomycin-resistant enterococci)	18	5	44	41

To report a notifiable disease, please contact:

Sexually transmitted diseases: Pat Petty at 340-5647
AIDS/HIV: Mary Angel-Beckner at 340-5330
Hepatitis B: Cherese Brooks at 340-2168
Tuberculosis: Diane Schmitt at 340-5650
Hepatitis C: Jennifer Blackmon at 340-5671
Vaccine-preventable diseases: Denise Stratz at 340-2174
All other notifiable diseases: Pam Trotter at 340-5632

Return Service Requested

Public Health Watch welcomes feedback, articles, letters, and suggestions. To communicate with *Public Health Watch* staff, please:

Telephone: (615) 340 - 5683
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